STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING _____ B. WING _____	03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF DYER	2300 GREAT LAKES DRIVE DYER, IN46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00085845. This visit was in conjunction with a Post Survey Revisit (PSR) to Complaint IN00083771 investigated on 12/28/10. This visit was in conjunction with a Post Survey Revisit (PSR) to Complaint IN00084299 investigated on 1/19/11. Complaint IN00085845 substantiated, federal/state deficiency related to the allegations are cited at F 224. Unrelated deficiencies cited. Survey dates: March 2 and 3, 2011 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Survey team: Janelyn Kulik, RN, TC Lara Richards, RN Heather Tuttle, RN Census bed type: SNF/NF: 142 Total: 142 Census payor type:	F0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 33 Medicaid: 90 Other: 19 Total: 142 Sample: 15 These deficiencies also reflect State findings in accordance with 410 IAC 16.2. Quality review completed 3-8-11 Cathy Emswiller RN			

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F0224 SS=G	Based on record review and interview the facility failed to ensure residents were free from neglect for 1 of 1 residents reviewed with percutaneous endoscopic gastrostomy tube (peg tube, a tube used for nutritional purposes) in a sample of 14 related to a nurses not flushing the resident's peg tube prior to administering medications resulting in the peg tube become clogged and the resident going to the hospital to have the peg tube replaced. (Resident #G) Findings include: The record for Resident #G was reviewed on 3/3/11 at 7:35 a.m. The resident's diagnoses included, but was not limited to, cerebral vascular accident (CVA, Stroke) and dysphasia (impairment of speech). A nursing note dated 2/18/11 at 8:00 a.m., indicated the resident was in bed asleep, unable to flush g-tube (gastrostomy tube, tube used for nutritional purposes). The resident's feeding had clogged the tube. Several attempts were made without success to unclog the tube. Bowel sounds were present in four abdominal quadrants. There was no tenderness noted. No facial grimaces at this time. At 8:30 a.m. the Nurse Practitioner was notified. An order	F0224	**F – 224** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident G's PEG tube was flushed at the time of survey. The licensed nurse responsible has been counseled/terminated. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents of the nursing center with enteral feeding tubes have the potential to be affected, therefore, this plan of correction applies to all residents with enteral feeding tubes. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Licensed nursing staff has been in-serviced related to care of enteral feeding tubes, including but not limited to proper technique for checking placement and water flushes according to physician order. Licensed nurses will complete a competency check off with return demonstration to ensure proper technique. The Staff Development Coordinator, or designee, shall observe enteral feeding tube procedures for at least 2 residents daily, on	03/21/2011

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	was received to place feeding on hold and to contact the physician who inserted the g-tube. The first available appointment with the physician was 2/21/11. The Nurse Practitioner was notified and an order was received to send the resident to the emergency room to have a new g-tube reinserted. At 10:00 a.m. the resident's daughter was made aware of the resident being transferred to the emergency room for an occluded g-tube and she was also made aware the g-tube was starting to rip. Review of a hospital history and physical with a date of admission of 2/18/11, indicated a chief complaint of malfunctioning g-tube. History of present illness: The resident had a g-tube in place which, on presentation, was malfunctioning and this prompted a transfer to the emergency room by the nursing home. The resident was seen promptly by the physician who took the resident for a endoscope (inspection of body organs or cavities with an endoscope) and replacement of the g-tube. The external bumper of the peg tube was noted to have migrated into the abdominal wall. This was removed and the old peg tube was replaced. Impression and plan: The resident was admitted with a malfunctioning g-tube. The external bumper of the tube was		scheduled days of work, for 30 days. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with proper technique for checking placement and water flushes according to physician order. The SDC, or her designee, will complete these indicators weekly for at least 2 residents for the first quarter and monthly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	

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	found to have migrated into the abdominal wall and required endoscopic removal and replacement. The resident was seen post-procedure and had been restarted on tube feeds. The resident will receive antibiotic in the short-term to cover for possible infection of the abdominal wall. If she tolerates tube feeds, timely discharge back to the nursing home anticipated. Review of a complaints/grievances form provided by the Administrator on 3/3/11 at 8:00 a.m., indicated on 2/1/8/11 the RN #1 reported the complaint on behalf of Resident #G's daughter. Issue: The resident's daughter was noted in the hallway and began to inform RN #1 that the resident's peg-tube had not been flushed. She also showed RN#1 pictures of the peg-tube on her cell phone. The peg-tube did appear to the nurse to be distended, balloon like. The nurse observed both the night and day nurse attempting to flush the peg-tube without success. Department response: RN #1 attempted to flush the peg tube and was unable to the flush the tube. RN#1 instructed the staff nurse to call the Nurse Practitioner for update and instructions. The Nurse Practitioner instructed staff to refer to the surgeon who place the peg-tube. The			

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	surgeon was out of town. The Nurse Practitioner was informed and instructed staff to sent the resident to the emergency room. The night nurse was also counseled regarding the incident. Resolution: The nurse was terminated for substandard care and public health was notified. Review of a reportable incident was provided by the administrator on 3/3/10 at 8:00 a.m. The date of the incident was 2/18/11 at 5:00 a.m. It was an unusual occurrence involving Resident #G and LPN #2. Event summary/type of injury: On the 2/18/11 at abut 8:00 a.m., it was brought to a QMA's attention by the resident's daughter, that the resident had a problem with her g-tube. Upon assessing the g-tube the RN noted that the tube was occluded and pouched out unnaturally. The night nurse was still in the facility and the RN took her aside and asked her what had happened during the medications administration this morning. "The night nurse said that she was busy and did not flush the g-tube. She did say that she dissolved the meds in water. Efforts to clear the tube were unsuccessful and the patient went to the ER for g-tube re-placement." The nurse was terminated after careful review of the events			

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	surrounding this mornings medication pass. The nurse admitted to knowing the policy on g-tube medication pass and stated she "cut corners" this morning as she was overwhelmed. Review of the "Medication via Feeding Tube" policy provided by the Director of Nursing (DoN) on 3/3/11 at 8:40 a.m. The procedure included, but was not limited to, stop tube feeding and disconnect the administration set, if applicable, inspect tube feeding site for: redness around site, swelling, excoriation around site, drainage, or foul odor, check feeding tube placement (feeding tube placement and residual check, flush feeding tube with at least 30 ml of warm water, unless contraindicated, remove plunger from the syringe, attach the syringe to the feeding tube, and pour the medication into the syringe. Interview with the DoN and the Interim DoN on 3/3/11 at 1:40 p.m., indicated the nurse should have never done what she did, there was no reason for what she did. It was further indicated LPN #2 was terminated and was being reported to the licensing board. This Federal tag relates to Complaint IN00085845.			

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	3.1-27(a)(3)			

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F0225 SS=D	Based on record review and interviews, the facility failed to ensure that all allegations of abuse were thoroughly investigated reported to the state agency for 2 of 5 allegations reviewed for abuse in the sample of 14. (Residents #O and #P) Findings include: The facility policy titled "Responding to and Investigating an Abuse Allegation" was reviewed on 3/3/11 at 10:00 a.m. The policy was provided by the Administrator and identified as current. The policy indicated the following: "Alleged Physical Abuse-Diffuse the situation, and remove the aggressor from all resident contact. If the resident could have an injury as a result of the alleged abuse, stabilize the resident's condition. Contact the Executive Director and Director of Nursing immediately." "For all abuse allegations, begin an internal investigation, immediately report the allegations to the Director of Operations, DDCO, Regional Vice President, Human Resources, and legal counsel (contact legal based upon the severity of the allegation or if further assistance is needed in the investigation)."	F0225	**F – 225** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The concerns voiced by Residents O and P have been investigated with follow up and reporting to the state department of health completed as necessary. Neither resident O or P incurred any negative outcome. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to be affected, therefore, this plan of correction applies to all residents of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has been in-serviced relative to Abuse Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse to the executive director and subsequent reporting to the state. Residents will be interviewed daily, Monday through Friday, for 30 days, to determine if any issues/concerns requiring further investigation are present. Investigations will be promptly	03/21/2011

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	1. A Grievance Communication/Response Form dated 2/15/11 was reviewed on 3/3/11 at 10:30 a.m. The Form indicated Resident #O had filed a grievance against the Therapy Department. Resident #O indicated "Therapist #2 (name) was very mean and rude to her and she told (name) she does not want her to help her anymore." The Department Response on 2/18/11 signed by a Certified Occupational Therapy Aide (COTA #1) indicated "Therapist has been switched out. (Therapist #2 name) is no longer working with her." The entire Communication/Response Form was signed by the Administrator as being complete on 3/2/11 with no further investigation. Interview with the Physical Therapist #1 on 3/3/11 at 11:40 a.m., indicated that a couple of days before she received this grievance form the therapist had come to her and indicated that Resident #O was not motivated and she had been pushing her. The Physical Therapist #1 then indicated that a couple of sessions later (did not remember the date) Resident #O had come to speak with her and indicated		initiated with appropriate reporting. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with investigating and reporting of any allegations of abuse. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	

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	she just did not get along with the Therapist #2 and wanted a new therapist. So at that time, the Physical Therapist had switched therapists and gave Resident #O a new one. Further interview with the Physical Therapist #1 at that time, indicated she did not report the incident to the Administrator, nor did she document any of conversations with the therapist or the resident. Physical Therapist #1 also indicated that when she received the grievance form she had done nothing else, because she had already switched therapists. She indicated even at that time, she still had not communicated with the Administrator and informed her of the events that happened days earlier. Interview with the Administrator on 3/3/11 at 11:40 a.m., indicated she was unaware of the entire situation that happened in the therapy department with Resident #O and the therapist. She also indicated at the time, that a further investigation of the resident's complaints of the therapist being "mean and rude" should have been completed. She also indicated the allegation of abuse had not been reported to the State Department of Health. 2. A Grievance Communication/Response Form dated			

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	2/21/11 was reviewed on 3/3/11 at 10:40 a.m. The form indicated Resident #P had filed a grievance against the Therapy Department. Resident #P had indicated that she did not want to attend therapy anymore because "they have a way of making her feel goofy." Review of the Department Response by the COTA #1 on 2/22/11 indicated "will attempt to have patient seen by another therapist." The Communication/Response Form was signed by the Administrator on 3/2/11 as being completed. There was no further investigation to the resident's allegations of the therapy department making her feel "goofy." Interview with the COTA #1 on 3/3/11 at 11:40 a.m., indicated the therapist in question came to her one day, and indicated the resident was not motivated to perform therapy and the resident did not want to work with her. The COTA #1 further indicated at the time, the resident was never interviewed, and she just reassigned the resident to another therapist. The COTA also indicated she did not inform the Administrator of the conversation and when she received the Grievance form she did not further			

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	investigate the allegations because the resident was reassigned to another therapist. Interview with Administrator on 3/3/11 at 11:40 a.m., indicated she was unaware of the entire situation. She further indicated she did not investigate the resident's allegation of the therapy department making her feel "goofy." She also indicated at the time, there should have been more investigation to the resident's complaints. She also indicated the allegation of abuse had not been reported to the State Department of Health. 3.1-28(c)			

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F0226 SS=D	Based on record review and interview, the facility failed to ensure their Abuse policy was followed as written related to the investigation and reporting allegations of abuse for 3 of 5 abuse allegations reviewed in the sample of 14. (Resident #F , #O and #P) Findings include: The facility policy titled "Responding to and Investigating an Abuse Allegation" was reviewed on 3/3/11 at 10:00 a.m. The policy was provided by the Administrator and identified as current. The policy indicated the following: "Alleged Physical Abuse-Diffuse the situation, and remove the aggressor from all resident contact. If the resident could have an injury as a result of the alleged abuse, stabilize the resident's condition. Contact the Executive Director and Director of Nursing immediately." "For all abuse allegations, begin an internal investigation, immediately report the allegations to the Director of Operations, DDCO, Regional Vice President, Human Resources, and legal counsel (contact legal based upon the severity of the allegation or if further assistance is needed in the investigation)."	F0226	**F – 226** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The concerns for resident F, O and P have been investigated with follow-up completed as necessary. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to be affected, therefore, this plan of correction applies to all residents of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has been in-serviced relative to Abuse Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse to the executive director and subsequent reporting to the state. Residents will be interviewed daily, Monday through Friday, for 30 days, to determine if any issues/concerns requiring further investigation are present. Investigations will be promptly initiated. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement	03/21/2011

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	1. The record for Resident #F was reviewed on 3/3/11 at 9:00 a.m. An entry in the Nursing Progress Notes dated 2/7/11 at 1:00 p.m., indicated the resident had hit another resident in the back of the head on 2/5/11. Review of the facility investigation on 3/3/11 at 3:00 p.m., indicated that on the evening of 2/5/11, the resident hit Resident #Q on the back of the head because she would not stop banging on the wall. The investigation also indicated the nurse on duty sent a text to the on call nurse. The on call nurse did not receive the text and the administrator was not informed of the resident to resident altercation until the morning of 2/7/11. Interview with the Administrator on 3/3/11 at 3:10 p.m., indicated the nurse on duty had been counseled related to how to notify staff of allegations of abuse. The Administrator further indicated that she should have been notified of the resident to resident altercation prior to 2/7/11.		indicator has been established which evaluates compliance with reporting of and investigation of any allegations of abuse. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	2. A Grievance Communication/Response Form dated 2/15/11 was reviewed on 3/3/11 at 10:30 a.m. The form indicated Resident #O had filed a grievance against the Therapy Department. Resident #O indicated "Therapist #2 (name) was very mean and rude to her and she told (name) she does not want her to help her anymore." The Department Response on 2/18/11 signed by a Certified Occupational Therapy Aide (COTA #1) indicated "Therapist #2 has been switched out. (Therapist #2's name) is no longer working with her." The entire Communication/Response Form was signed by the Administrator as being complete on 3/2/11 with no further investigation. Interview with the Physical Therapist #1 on 3/3/11 at 11:40 a.m., indicated that a couple of days before she received this grievance form the therapist had come to her and indicated that Resident #O was not motivated and she had been pushing her. The Physical Therapist #1 then indicated that a couple of sessions later (did not remember the date) Resident #O had come to speak with her and indicated she just did not get along with the	F0226	**F – 226** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The concerns for resident F, O and P have been investigated with follow-up completed as necessary. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to be affected, therefore, this plan of correction applies to all residents of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has been in-serviced relative to Abuse Prevention, including but not limited to, definitions of abuse and immediate reporting of abuse to the executive director and subsequent reporting to the state. Residents will be interviewed daily, Monday through Friday, for 30 days, to determine if any issues/concerns requiring further investigation are present. Investigations will be promptly initiated. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement	03/21/2011

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	155218	A. BUILDING _____ B. WING _____	03/03/2011

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	Therapist #2 and wanted a new therapist. So at that time, the Physical Therapist #1 had switched therapists and gave Resident #O a new one. Further interview with the Physical Therapist #1 at that time, indicated she did not report the incident to the Administrator, nor did she document any of conversations with the therapist or the resident. The Physical Therapist also indicated that when she received the grievance form she had done nothing else, because she had already switched therapists. She indicated even at that time, she still had not communicated with the Administrator and informed her of the events that happened days earlier. Interview with the Administrator on 3/3/11 at 11:40 a.m., indicated she was unaware of the entire situation that happened in the therapy department with Resident #O and the therapist. She also indicated at the time, that a further investigation of the resident's complaints of the therapist being "mean and rude" should have been completed. She also indicated the allegation of abuse had not been reported to the State Department of Health. 3. A Grievance Communication/Response Form dated 2/21/11 was reviewed on 3/3/11 at 10:40		indicator has been established which evaluates compliance with reporting of and investigation of any allegations of abuse. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	

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	a.m. The form indicated Resident #P had filed a grievance against the Therapy Department. Resident #P had indicated that she did not want to attend therapy anymore because "they have a way of making her feel goofy." Review of the Department Response by the COTA #1 on 2/22/11 indicated "will attempt to have patient seen by another therapist." The Communication/Response Form was signed by the Administrator on 3/2/11 as being completed. There was no further investigation to the resident's allegations of the therapy department making her feel "goofy." Interview with the COTA #1 on 3/3/11 at 11:40 a.m., indicated the therapist in question came to her one day, and indicated the resident was not motivated to perform therapy and the resident did not want to work with her. The COTA #1 further indicated at the time, the resident was never interviewed, and she just reassigned the resident to another therapist. The COTA also indicated she did not inform the Administrator of the conversation and when she received the Grievance form she did not further investigate the allegations because the			

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	resident was reassigned to another therapist. Interview with Administrator on 3/3/11 at 11:40 a.m., indicated she was unaware of the entire situation. She further indicated she did not investigate the resident's allegation of the therapy department making her feel "goofy." She also indicated at the time, there should have been more investigation to the resident's complaints. She also indicated the allegation of abuse had not been reported to the State Department of Health. 3.1-28(a)			

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F0250 SS=D	Based on record review and interview, the facility failed to ensure medically-related social services were provided to 1 of 1 residents who exhibited an increase in behaviors in the sample of 14 related to arranging counseling services and monitoring behaviors. (Resident #F) Findings include: The record for Resident #F was reviewed on 3/3/11 at 9:00 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance. A Physician's Order written on 1/24/11, indicated the resident was to be seen by Senior Counseling Services related to grieving loss of husband with behaviors. An entry in the Nursing Progress Notes dated 2/3/11 at 1:20 a.m., indicated orders were found on the chart for the resident to be seen by Senior Counseling Services for evaluation and treatment related to grieving loss of spouse with behaviors. The nurse was going to endorse to the next shift to notify the family at a reasonable hour of the order. There was no documentation in the resident's record from Senior Counseling Services. An entry in the Nursing Progress Notes dated 2/7/11 at 1:00 p.m., completed by	F0250	**F – 250** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident F has received Senior Counseling Services. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: The medical records of all residents have been audited to identify any outstanding referrals with follow up implemented, as necessary. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff and social services staff has been in-serviced relative to appropriate interventions to implement when residents exhibit behaviors, and ensuring referrals are followed up on timely. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with appropriate intervention and referrals for residents exhibiting behaviors. SSD, or designee, will be responsible to review behavior audit tool daily, on scheduled days of work, during morning	03/21/2011

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	the Director of Nursing, indicated the resident had hit another Resident #Q on 2/5/11 due to the resident was hitting the wall and would not stop. On the morning of 2/7/11, the resident had hit another Resident #D in the back of the head without being provoked. When she was redirected, she came back to the area and attempted to yell at Resident #E. The resident's sister was informed as well as the facility psychiatric nurse practitioner. A Nurse Practitioner order dated 2/8/11, indicated the resident was to receive Haldol (an anti-psychotic medication) 2 milligrams (mg) by mouth or intramuscular now. Haldol 1 mg by mouth twice a day for seven days and psych to evaluate and treat. The February 2011 Behavior Monthly Flowsheet, indicated the resident had the behavior of verbally abusive, wanders, and physically abusive. The flow sheet was blank 2/1-2/3 and 2/5-2/10/11. The behaviors on 2/5 and 2/7/11 were not listed on the flow sheet. The Quarterly Minimum Data Set Assessment (MDS) dated 1/11/11, indicated the resident displayed physical and verbal behavioral symptoms towards others.		meeting. SSD, or designee, will complete the indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	

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	The resident was seen by the facility Psychiatric Nurse Practitioner on 2/10/11. Interview with Social Service Staff Member #1 on 3/3/11 at 1:25 p.m., indicated when an order for psychiatric services were obtained, Nursing staff were to inform Social Service staff of the order and then the order was faxed to the appropriate agency. Further interview with Social Service Staff Member #1, indicated Senior Counseling Services were not faxed the order until 2/3/11. She further indicated that she had to re-fax the resident's payor status on 3/1/11 due to the payor status not listed on the face sheet that was originally faxed. As of 3/3/11, the Social Service staff member indicated the resident had not been seen by Senior Counseling Services. 3.1-34(a)			

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F0282 SS=G	Based on observation, record review and interview, the facility failed to ensure physician's orders were followed as written related to obtaining a consultation for psychiatric counseling services and having leg rests on the wheelchair as ordered for 2 of 14 sampled residents. (Residents #F and #O) The facility also failed to ensure the plan of care was followed as written related to foley catheter care for 1 of 2 residents who had a foley catheter in the sample of 14 and failed to ensure the resident's peg tube (percutaneous endoscopic gastrostomy tube, a tube used for nutritional purposes) was flushed prior to the resident receiving medications through the peg tube resulting in the peg tube become clogged and the resident going to the hospital to have the peg tube replaced. (Resident #G) Findings include: 1. The record for Resident #F was reviewed on 3/3/11 at 9:00 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance. A Physician's Order written on 1/24/11, indicated the resident was to be seen by Senior Counseling Services related to grieving loss of husband with behaviors.	F0282	**F – 282** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident F has received Senior Counseling Services. Resident G's urinary drainage bag was placed in a dignity bag off the floor and her PEG tube was flushed during the survey. Resident O had leg rests applied to wheelchair. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: The medical records of all residents have been audited to identify any outstanding referrals with follow up implemented, as necessary. Residents with foley catheters have been visually observed to ensure presence of dignity bags. An audit has been conducted to ensure necessary assistive devices are in use. All residents of the nursing center with enteral feeding tubes have the potential to be affected, therefore, this plan of correction applies to all residents with enteral feeding tubes.The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has	03/21/2011

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	An entry in the Nursing Progress Notes dated 2/3/11 at 1:20 a.m., indicated orders were found on the chart for the resident to be seen by Senior Counseling Services for evaluation and treatment related to grieving loss of spouse with behaviors. The nurse was going to endorse to the next shift to notify the family at a reasonable hour of the order. There was no documentation in the resident's record from Senior Counseling Services. Interview with Social Service Staff Member #1 on 3/3/11 at 1:25 p.m., indicated when an order for psychiatric services were obtained, Nursing staff were to inform Social Service staff of the order and then the order was faxed to the appropriate agency. Further interview with Social Service Staff Member #1, indicated Senior Counseling Services were not faxed the order until 2/3/11. She further indicated that she had to re-fax the resident's payor status on 3/1/11 due to the payor status not listed on the face sheet that was originally faxed. As of 3/3/11, the Social Service staff member indicated the resident had not been seen by Senior Counseling Services.		been in-serviced relative to appropriate interventions to implement when residents exhibit behaviors, and ensuring referrals are followed up on timely. Licensed nurses and C.N.A.'s have been in-serviced relative to foley catheters, including but not limited to ensuring a dignity bag is in use. Nursing center staff has been in-serviced relative to the importance of ensuring assistive devices are in use in accordance with physician orders and careplans. Licensed nursing staff has been in-serviced related to care of enteral feeding tubes, including but not limited to proper technique for checking placement and water flushes according to physician order. Licensed nurses will complete a competency check off with return demonstration to ensure proper technique. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator that monitors foley catheters, peg tubes and assistive devices has been established which evaluates compliance with ensuring physician orders and careplans are followed. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation	

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			or resolution until 100% compliance is achieved. A Performance Improvement indicator has been established which evaluates compliance with proper technique for checking placement and water flushes according to physician order.The Staff Development Coordinator, or designee, shall observe enteral feeding tube procedures for at least 2 residents daily, on scheduled days of work, for 30 days and monthly there after. The results will be forwarded to the performance improvement committee for further evaluation or resolution until 100% compliance is achieved.POC date: 3/21/2011	

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F0282 SS=G	2. On 3/2/11 at 12:45 p.m. and at 2:15 p.m., Resident #O was observed sitting in her wheelchair with both of her feet on the floor. There were no leg rests noted on her wheelchair and her legs were observed in the dependent position. On 3/3/11 at 9:30 a.m., Resident #O was observed in bed. At that time, the South Unit Manager removed the resident's anti-embolytic stockings (ted) hose and performed a skin assessment. The resident's legs were edematous and slightly red in color. Both of the resident's feet were edematous. The resident was observed with deep tissue injury to her left heel. The area was dark red with no drainage. Interview with the resident at that time, indicated her legs hurt because of the swelling. On 3/3/11 at 10:00 a.m., Resident# O was observed sitting in her wheelchair in the main dining room in a church activity. Both of the resident's legs were in the dependent position and there were no wheelchair leg rests observed on the her chair. The record for Resident #O was reviewed on 3/2/11 at 12:45 p.m. Review of	F0282	**F – 282** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident F has received Senior Counseling Services. Resident G's urinary drainage bag was placed in a dignity bag off the floor and her PEG tube was flushed during the survey. Resident O had leg rests applied to wheelchair. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: The medical records of all residents have been audited to identify any outstanding referrals with follow up implemented, as necessary. Residents with foley catheters have been visually observed to ensure presence of dignity bags. An audit has been conducted to ensure necessary assistive devices are in use. All residents of the nursing center with enteral feeding tubes have the potential to be affected, therefore, this plan of correction applies to all residents with enteral feeding tubes.The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has	03/21/2011

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	Physician orders dated 2/11/11 indicated "Encourage resident to elevate legs, needs two foot rests that will elevate her legs." Interview with the South Unit Manager on 3/3/11 at 9:45 a.m., indicated the resident did not have leg rests on her wheelchair.		been in-serviced relative to appropriate interventions to implement when residents exhibit behaviors, and ensuring referrals are followed up on timely. Licensed nurses and C.N.A.'s have been in-serviced relative to foley catheters, including but not limited to ensuring a dignity bag is in use. Nursing center staff has been in-serviced relative to the importance of ensuring assistive devices are in use in accordance with physician orders and careplans. Licensed nursing staff has been in-serviced related to care of enteral feeding tubes, including but not limited to proper technique for checking placement and water flushes according to physician order. Licensed nurses will complete a competency check off with return demonstration to ensure proper technique. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator that monitors foley catheters, peg tubes and assistive devices has been established which evaluates compliance with ensuring physician orders and careplans are followed. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation	

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F0282 SS=G	3. On 3/3/11 at 7:10 a.m. Resident #G was observed in bed with her foley bag laying on the mat on the floor by her bed. The foley bag was not contained in a dignity bag (a bag used to hold the foley catheter bag so that it cannot be seen or touch the floor). On 3/3/11 at 7:20 a.m. Resident #G was observed in bed with her foley bag laying on the floor mat beside her bed. The CNA moved the floor mat and the bottom of the foley bag was touching the floor. The foley bag was not contained in a dignity bag. On 3/3/11 at 8:55 a.m. the resident was observed in bed with her foley bag touching the floor mat beside her bed and the floor. The foley bag was not contained in a dignity bag. On 3/3/11 at 9:45 a.m. the resident was observed in bed with her foley bag touching the mat on the floor beside her bed and the floor. The foley bag was not contained in a dignity bag. The resident's record was reviewed on 3/3/11 at 7:35 a.m. The record for Resident #G was reviewed on 3/3/11 at 7:35 a.m. The resident's diagnoses included, but was not limited to, cerebral	F0282	**F – 282** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident F has received Senior Counseling Services. Resident G's urinary drainage bag was placed in a dignity bag off the floor and her PEG tube was flushed during the survey. Resident O had leg rests applied to wheelchair. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: The medical records of all residents have been audited to identify any outstanding referrals with follow up implemented, as necessary. Residents with foley catheters have been visually observed to ensure presence of dignity bags. An audit has been conducted to ensure necessary assistive devices are in use. All residents of the nursing center with enteral feeding tubes have the potential to be affected, therefore, this plan of correction applies to all residents with enteral feeding tubes.The measures put into place and systemic change made to ensure the deficient practice does not recur is: Nursing center staff has	03/21/2011

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	155218	A. BUILDING _____ B. WING _____	03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF DYER	2300 GREAT LAKES DRIVE DYER, IN46311

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	vascular accident (CVA, Stroke), chronic UTI (urinary tract infection), and dysphasia (impairment of speech). A care plan initiated on 6/25/10, indicated a problem of at risk for complications related to foley catheter usage. The approaches included but were not limited to, place catheter bag in a dignity bag for privacy. On 3/3/10 at 1: 40 p.m. interview with the Director on Nursing and Interim Director of Nursing, it was indicated that the foley bag of Resident #G was observed last night. The Director of Nursing indicated she thought to get a dignity bag but had not obtained the dignity bag for the resident. 4. A nursing note dated 2/18/11 at 8:00 a.m., indicated the Resident #G was in bed asleep, unable to flush g-tube (gastrostomy tube, tube used for nutritional purposes). The resident's feeding had clogged the tube. Several attempts were made without success to unclog the tube. Bowel sounds were present in four abdominal quadrants. There was no tenderness noted. No facial grimaces at this time. At 8:30 a.m. the Nurse Practitioner was notified. An order was received to place feeding on hold and		been in-serviced relative to appropriate interventions to implement when residents exhibit behaviors, and ensuring referrals are followed up on timely. Licensed nurses and C.N.A.'s have been in-serviced relative to foley catheters, including but not limited to ensuring a dignity bag is in use. Nursing center staff has been in-serviced relative to the importance of ensuring assistive devices are in use in accordance with physician orders and careplans. Licensed nursing staff has been in-serviced related to care of enteral feeding tubes, including but not limited to proper technique for checking placement and water flushes according to physician order. Licensed nurses will complete a competency check off with return demonstration to ensure proper technique. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator that monitors foley catheters, peg tubes and assistive devices has been established which evaluates compliance with ensuring physician orders and careplans are followed. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly thereafter with results forwarded to the facility performance improvement committee for further evaluation	

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	to contact the physician who inserted the g-tube. The first available appointment with the physician was 2/21/11. The Nurse Practitioner was notified and an order was received to send the resident to the emergency room to have a new g-tube reinserted. At 10:00 a.m. the resident's daughter was made aware of the resident being transferred to the emergency room for an occluded g-tube and she was also made aware the g-tube was starting to rip. An Admission order record dated 2/21/11, indicated to flush peg tube with 5 ml (milliliters) of water before and after each medications and to flush peg tube with 30 ml of water before and after medication administration. Review of a hospital history and physical with a date of admission of 2/18/11, indicated a chief complaint of malfunctioning g-tube. History of present illness: The resident had a g-tube in place which, on presentation, was malfunctioning and this prompted a transfer to the emergency room by the nursing home. The resident was seen promptly by the physician who took the resident for a endoscope (inspection of body organs or cavities with an endoscope) and replacement of the g-tube. The external bumper of the		or resolution until 100% compliance is achieved. A Performance Improvement indicator has been established which evaluates compliance with proper technique for checking placement and water flushes according to physician order.The Staff Development Coordinator, or designee, shall observe enteral feeding tube procedures for at least 2 residents daily, on scheduled days of work, for 30 days and monthly there after. The results will be forwarded to the performance improvement committee for further evaluation or resolution until 100% compliance is achieved.POC date: 3/21/2011	

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	peg tube was noted to have migrated into the abdominal wall. This was removed and the old peg tube was replaced. Impression and plan: The resident was admitted with a malfunctioning g-tube. The external bumper of the tube was found to have migrated into the abdominal wall and required endoscopic removal and replacement. The resident was seen post-procedure and had been restarted on tube feeds. The resident will receive antibiotic in the short-term to cover for possible infection of the abdominal wall. If she tolerates tube feeds, timely discharge back to the nursing home anticipated. Review of a complaints/grievances form provided by the Administrator on 3/3/11 at 8:00 a.m., indicated on 2/1/8/11 the RN #1 reported the complaint on behalf of Resident #G's daughter. Issue: The resident's daughter was noted in the hallway and began to inform RN #1 that the resident's peg-tube had not been flushed. She also showed RN#1 pictures of the peg-tube on her cell phone. The peg-tube did appear to the nurse to be distended, balloon like. The nurse observed both the night and day nurse attempting to flush the peg-tube without success. Department response: RN #1 attempted			

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	to flush the peg tube and was unable to the flush the tube. RN#1 instructed the staff nurse to call the Nurse Practitioner for update and instructions. The Nurse Practitioner instructed staff to refer to the surgeon who place the peg-tube. The surgeon was out of town. The Nurse Practitioner was informed and instructed staff to sent the resident to the emergency room. The night nurse was also counseled regarding the incident. Resolution: The nurse was terminated for substandard care and public health was notified. Review of a reportable incident was provided by the administrator on 3/3/10 at 8:00 a.m. The date of the incident was 2/18/11 at 5:00 a.m. It was an unusual occurrence involving Resident #G and LPN #2. Event summary/type of injury: On the 2/18/11 at abut 8:00 a.m., it was brought to a QMA's attention by the resident's daughter, that the resident had a problem with her g-tube. Upon assessing the g-tube the RN noted that the tube was occluded and pouched out unnaturally. The night nurse was still in the facility and the RN took her aside and asked her what had happened during the medications administration this morning. "The night nurse said that she was busy			

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	and did not flush the g-tube. She did say that she dissolved the meds in water. Efforts to clear the tube were unsuccessful and the patient went to the ER for g-tube re-placement." The nurse was terminated after careful review of the events surrounding this mornings medication pass. The nurse admitted to knowing the policy on g-tube medication pass and stated she "cut corners" this morning as she was overwhelmed. Review of the "Medication via Feeding Tube" policy provided by the Director of Nursing (DoN) on 3/3/11 at 8:40 a.m. The procedure included, but was not limited to, stop tube feeding and disconnect the administration set, if applicable, inspect tube feeding site for: redness around site, swelling, excoriation around site, drainage, or foul odor, check feeding tube placement (feeding tube placement and residual check, flush feeding tube with at least 30 ml of warm water, unless contraindicated, remove plunger from the syringe, attach the syringe to the feeding tube, and pour the medication into the syringe. Interview with the DoN and the Interim DoN on 3/3/11 at 1:40 p.m., indicated the nurse should have never done what she did, there was no reason for what she did.			

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	It was further indicated LPN #2 was terminated and was being reported to the licensing board. 3.1-35(g)(2)			

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F0315 SS=D	Based on observation, record review and interview the facility failed to ensure that 1 of 4 residents reviewed with a history of urinary tract infections in a sample of 14 received the appropriate treatment and services to prevent urinary tract infections related to a foley catheter bag not being contained in a dignity bag (a bag used to hold the foley catheter bag so that it cannot be seen and will not touch the floor) and lying on the floor. (Resident #G) Findings included: On 3/3/11 at 7:10 a.m. Resident #G was observed in bed with her foley catheter bag laying on the mat on the floor by her bed. The foley catheter bag was not contained in a dignity bag. On 3/3/11 at 7:20 a.m. Resident #G was observed in bed with her foley catheter bag laying on the floor mat beside her bed. The CNA moved the floor mat and the bottom of the foley catheter bag was touching the floor. The foley catheter bag was not contained in a dignity bag. On 3/3/11 at 8:55 a.m. the resident was observed in bed with her foley catheter bag touching the floor mat beside her bed and the floor. The foley catheter bag was	F0315	**F – 315** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident G's urinary drainage bag was placed in a dignity bag off the floor during the survey. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents with foley catheters have the potential to be affected, therefore, this plan of correction applies to all residents of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Licensed nursing staff and C.N.A.'s have been inserviced related to the policy and procedure related to urinary bag placement and the use of dignity covers. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with urinary bag placement and the use of dignity covers. The DNS or her representative will complete these indicators monthly for the first quarter and quarterly	03/21/2011

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	not contained in a dignity bag. On 3/3/11 at 9:45 a.m. the resident was observed in bed with her foley catheter bag touching the mat on the floor beside her bed and the floor. The foley catheter bag was not contained in a dignity bag. The resident's record was reviewed on 3/3/11 at 7:35 a.m. The resident's diagnoses included, but was not limited to, chronic urinary tract infection (UTI). A care plan initiated on 6/25/10, indicated a problem of at risk for complications related to foley catheter usage. The approaches included but were not limited to, place catheter bag in a dignity bag for privacy. Interview with RN #2 on 3/3/11 at 8:10 a.m. indicated Resident #G did have chronic UTI. Review of the Indwelling Urinary Catheter Care Policy provided by the Director of Nursing on 3/3/11 at 10:20 a.m., indicated the rational of, "Care of a catheter is provided to prevent infection and /or reduce irritation." The procedure included, but not limited to, "Position the collecting-bag below the level of the bladder at all times. Do not rest the bag		thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/11	

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	on the floor." On 3/3/10 at 1: 40 p.m. interview with the Director on Nursing and Interim Director of Nursing, it was indicated that the foley catheter bag of Resident #G was observed last night. The Director of Nursing indicated she thought to get a dignity bag but had not obtained the dignity bag for the resident. 3.1-41(a)(2)			

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F0322 SS=G	Based on observation, interview, and record review the facility failed to ensure appropriate treatment and services were provided to 1 of 1 resident with a percutaneous endoscopic gastrostomy tube (peg tube, a tube used for nutritional purposes) in a sample of 14 residents related to the nurse failing flush the resident's peg tube prior to administering medications resulting in the peg tube becoming clogged and the resident being sent to the hospital to have the peg tube replaced and the nurse failing to verify placement and checking residual prior to administering medications. (Resident #G). Findings include: 1. The record for Resident #G was reviewed on 3/3/11 at 7:35 a.m. The resident's diagnoses included, but was not limited to, cerebral vascular accident (CVA, Stroke) and dysphasia (impairment of speech). A nursing note dated 2/18/11 at 8:00 a.m., indicated the resident was in bed asleep, unable to flush g-tube (gastrostomy tube, tube used for nutritional purposes). The resident's feeding had clogged the tube. Several attempts were made without	F0322	**F – 322** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident G's enteral feeding tube was checked for placement with an air bolus, with proper placement verified. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents of the nursing center with enteral feeding tubes have the potential to be affected, therefore, this plan of correction applies to all residents with enteral feeding tubes. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Licensed nursing staff has been in-serviced related to care of enteral feeding tubes, including but not limited to proper technique for checking placement and water flushes according to physician order. Licensed nurses will complete a competency check off with return demonstration to ensure proper technique.The Staff Development Coordinator, or designee, shall observe enteral feeding tube procedures for at least 2 residents daily, on scheduled	03/21/2011

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	success to unclog the tube. Bowel sounds were present in four abdominal quadrants. There was no tenderness noted. No facial grimaces at this time. At 8:30 a.m. the Nurse Practitioner was notified. An order was received to place feeding on hold and to contact the physician who inserted the g-tube. The first available appointment with the physician was 2/21/11. The Nurse Practitioner was notified and an order was received to send the resident to the emergency room to have a new g-tube reinserted. At 10:00 a.m. the resident's daughter was made aware of the resident being transferred to the emergency room for an occluded g-tube and she was also made aware the g-tube was starting to rip. Review of a hospital history and physical with a date of admission of 2/18/11, indicated a chief complaint of malfunctioning g-tube. History of present illness: The resident had a g-tube in place which, on presentation, was malfunctioning and this prompted a transfer to the emergency room by the nursing home. The resident was seen promptly by the physician who took the resident for a endoscope (inspection of body organs or cavities with an endoscope) and replacement of the g-tube. The external bumper of the peg tube was noted to have migrated into		days of work, for 30 days. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with proper technique for checking placement and water flushes according to physician order. The SDC, or her designee, will complete these indicators weekly for at least 2 residents for the first quarter and monthly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	

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	the abdominal wall. This was removed and the old peg tube was replaced. Impression and plan: The resident was admitted with a malfunctioning g-tube. The external bumper of the tube was found to have migrated into the abdominal wall and required endoscopic removal and replacement. The resident was seen post-procedure and had been restarted on tube feeds. The resident will receive antibiotic in the short-term to cover for possible infection of the abdominal wall. If she tolerates tube feeds, timely discharge back to the nursing home anticipated. Review of a complaints/grievances form provided by the Administrator on 3/3/11 at 8:00 a.m., indicated on 2/1/8/11 the RN #1 reported the complaint on behalf of Resident #G's daughter. Issue: The resident's daughter was noted in the hallway and began to inform RN #1 that the resident's peg-tube had not been flushed. She also showed RN#1 pictures of the peg-tube on her cell phone. The peg-tube did appear to the nurse to be distended, balloon like. The nurse observed both the night and day nurse attempting to flush the peg-tube without success. Department response: RN #1 attempted to flush the peg tube and was unable to			

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	the flush the tube. RN#1 instructed the staff nurse to call the Nurse Practitioner for update and instructions. The Nurse Practitioner instructed staff to refer to the surgeon who place the peg-tube. The surgeon was out of town. The Nurse Practitioner was informed and instructed staff to sent the resident to the emergency room. The night nurse was also counseled regarding the incident. Resolution: The nurse was terminated for substandard care and public health was notified. Review of a reportable incident was provided by the administrator on 3/3/10 at 8:00 a.m. The date of the incident was 2/18/11 at 5:00 a.m. It was an unusual occurrence involving Resident #G and LPN #2. Event summary/type of injury: On the 2/18/11 at abut 8:00 a.m., it was brought to a QMA's attention by the resident's daughter, that the resident had a problem with her g-tube. Upon assessing the g-tube the RN noted that the tube was occluded and pouched out unnaturally. The night nurse was still in the facility and the RN took her aside and asked her what had happened during the medications administration this morning. "The night nurse said that she was busy and did not flush the g-tube. She did say			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that she dissolved the meds in water. Efforts to clear the tube were unsuccessful and the patient went to the ER for g-tube re-placement." The nurse was terminated after careful review of the events surrounding this mornings medication pass. The nurse admitted to knowing the policy on g-tube medication pass and stated she "cut corners" this morning as she was overwhelmed. Review of the "Medication via Feeding Tube" policy provided by the Director of Nursing (DoN) on 3/3/11 at 8:40 a.m. The procedure included, but was not limited to, stop tube feeding and disconnect the administration set, if applicable, inspect tube feeding site for: redness around site, swelling, excoriation around site, drainage, or foul odor, check feeding tube placement (feeding tube placement and residual check, flush feeding tube with at least 30 ml of warm water, unless contraindicated, remove plunger from the syringe, attach the syringe to the feeding tube, and pour the medication into the syringe. Interview with the DoN and the Interim DoN on 3/3/11 at 1:40 p.m., indicated the nurse should have never done what she did, there was no reason for what she did. It was further indicated LPN #2 was			

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	155218	A. BUILDING _____ B. WING _____	03/03/2011

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	terminated and was being reported to the licensing board. 2. On 3/3/11 at 7:20 a.m. LPN #1 was observed entering the room of Resident #G with five medication cups containing medications. The LPN put on gloves raised the head of the bed slightly higher than it was and informed the resident of what she was going to do. The nurse removed her gloves walked back to the medication cart to obtain her stethoscope and returned. She put on gloves and turned off the feeding pump. The LPN indicated she need to listen for the "swish". She disconnected the feeding pump for the peg tube, attached a 60 ml (milliliter) syringe, placed stethoscope on resident abdomen and poured approximately 60 cc of water into the syringe and administered the water by gravity. She then removed her stethoscope and proceeded to administer the five medication. Each medication was followed by 30 to 60 cc of water. Review of the "Medication via Feeding Tube" policy provided by the Director of Nursing (DoN) on 3/3/11 at 8:40 a.m. The procedure included, but was not limited to, stop tube feeding and disconnect the administration set, if applicable, inspect tube feeding site for:			

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redness around site, swelling, excoriation around site, drainage, or foul odor, check feeding tube placement (feeding tube placement and residual check, flush feeding tube with at least 30 ml of warm water, unless contraindicated, remove plunger from the syringe, attach the syringe to the feeding tube, and pour the medication into the syringe.

The Feeding Tube Placement and Residual Check policy was provided by the Director of Nursing on 3/3/11 at 9:50 a.m. The rationale: "The placement of the gastric tube is checked by aspiration to validate that the tube is in the stomach and the nasogastric tube is checked by auscultation (listening) to validate that the tube has not migrated or is not misplaced to another location such as the lungs
This procedure is appropriate for g-tubes, j-tubes, and n/g tubes."
G-tubes were to be checked included, but was not limited to, before each feeding and/or flush and before administering medications via tube.
The procedure included, but was not limited to, "for g-tubes and n/g tubes, attach syringe to feeding tube, and gently aspirate stomach contents.

Interview with LPN #1 on 3/3/11 at 7:30 a.m., indicated she checked the "swish by

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	putting water in the syringe and listening. Interview with RN #2 (weekend manager), on 3/3/11 at 11:15 a.m., indicated prior to using a peg for a initiating a feeding or giving medications the nurse should auscultate with an air bolus, check residual, and flush the tube with water.. Interview with the DoN and the Interim DoN on 3/3/11 at 1:40 p.m., indicated she had nothing to add if the LPN did not check placement prior to administering the water to the peg tube for Resident #G. 3.1-44(a)(2)			

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F0505 SS=D	Based on record review and interviews, the facility failed to ensure the resident's physician was promptly notified of laboratory results related to an urinalysis and culture and sensitivity for 1 of 14 sampled residents. (Resident #L) Findings include: The record for Resident #L was reviewed on 3/2/11 at 1:15 p.m. An urinalysis was collected for the resident on 2/22/11 with the final culture results reported back to the facility on 2/24/11 at 11:32 a.m. The final culture results indicated "Probable skin flora contamination, collect a new specimen if clinically indicated." Review of Physician orders dated 2/26/11 indicated to straight cath for a urinalysis. Review of Nurses Notes dated 2/27/11 indicated "Straight cath performed urine cloudy, yellow with visible sediment, strong odor present." Review of Nurses Notes dated 2/24 and 2/25/11 indicated there was no documentation the resident's physician had been notified of the need to get another urine sample. Interview with the South Unit Manager on 3/3/11 at 9:00 a.m., indicated there was a	F0505	**F – 505** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: The physician was notified of the delay in treatment with no new orders being received. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to be affected, therefore, this plan of correction applies to all residents of the nursing center. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Licensed nursing staff has been in-serviced relative to appropriate and timely follow up related to obtaining and follow up related to laboratory results. Labs will be reviewed during Monday through Friday clinical meetings to assure prompt follow-up and results. To ensure the deficient practice does not recur, the monitoring system established is: A Performance Improvement indicator has been established which evaluates compliance with obtaining and follow up on laboratory results to include timliness. The DNS, or her designee, will complete these	03/21/2011

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	delay in notifying the resident's physician of the urine culture results. 3.1-49(e)(2)		indicators weekly for at least 2 residents for the first quarter and monthly thereafter with results forwarded to the facility performance improvement committee for further evaluation or resolution until 100% compliance is achieved. POC date: 3/21/2011	